

Professional Licensing Agency
 402 West Washington Street
 Room W072
 Indianapolis, Indiana 46204



Michael R. Pence
Governor of Indiana
Nicholas W. Rhoad
PLA Executive Director

The nurse who is requesting that you complete this form has been placed on probation by the Indiana State Board of Nursing. As a term of this probation, the nurse is to ensure that a quarterly employer report is submitted by the nurse's employer until the nurse is released from the Order. This form may be obtained from the Board's webpage (www.in.gov) or by contacting the Compliance Office at Indiana Professional Licensing Agency at 317-234-2043.

Reporting Period From:	To:	Report Due:
Name of Employee		License Number
Employing Facility		Telephone Number
Address		City
State		Zip Code
Name and Position of Immediate Supervisor		
Date of Initial Employment		
Position		
ATTENDENCE Number of hours practiced since the last reporting period: Number of days absent since the last reporting period: Number of days tardy since the last reporting period: Explain reasons for absences and/or tardiness:		

PLEASE ANSWER THE FOLLOWING QUESTIONS AND EXPLAIN WHERE APPROPRIATE

Has there been a change in position or responsibilities since the last reporting period?	No	Yes
Have you identified any performance deficiencies? If yes please explain how those have been addressed below.	No	Yes
To the best of your knowledge, do you believe this employee is maintaining abstinence from all mood altering chemicals, including alcohol?	N/A	No
To the best of your knowledge, do you believe the employee is fully adhering to your agency's rules, policies, procedures, and duties as outlined in his/her job description?	No	Yes
Since the last report has the employee had any employment disciplinary concerns, incident reports, concerns reported about this nurse, or corrective action?	No	Yes
COMMENTS AND EXPLANATIONS:		

EVALUATION OF EMPLOYEE

E- EXCELLENT S- SATISFACTORY

NI- NEEDS IMPROVEMENT (EXPLAIN)

FACTORS	E	S	NI	STRENGTHS	OPPORTUNITIES FOR IMPROVEMENT
Adherence to Facilities Policies and Procedures					
Assessment Skills					
Attendance/Punctuality					
Communication Skills					
Cooperation/Attitude					
Documentation Skills					
General Appearance					
Medication Administration					
Quality of Patient Care					
Supervision/Delegation					
Work Relationships with coworkers					
Overall Performance					

MEDICATION DUTIES

Does this employee administer medications?	Yes	No
Are there any restrictions to what medication this employee can administer?	Yes	No
Does this nurse have access to medications?	Yes	No
How often are medication records reviewed for accuracy?		
Have any discrepancies been discovered? If yes please explain.		

NOTIFICATION OF BOARD ORDER

Where you informed of the Board Order by the nurse?
Were you provided with a COMPLETE copy of the Board Order by the nurse?
Did you sign a copy of the Board Order and return it to the Indiana State Board of Nursing?

SIGNATURE OF SUPERVISOR

Signature of Supervising Nurse	Title
Telephone Number	Date

Please send completed form along with a cover letter on company letterhead to:

Indiana State Board of Nursing
402 W. Washington Street, RM W072
Indianapolis, IN 46204

Or via email to: probation2@lpa.in.gov

Your cooperation regarding this matter is greatly appreciated.